# **NOTICE OF TEMPORARY SERVICE SUSPENSION**

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Date [insert date of written notice]

Person/Legal Guardian

Address

City, State Zip

re: Temporary Service Suspension

 Name

 DOB

 PMI

Dear [the person receiving services or legal representative]:

This letter is notification of temporary service suspension for [name of person receiving services]. You are currently receiving services funded by the following waiver program: \_\_BI, \_\_CAC, \_\_CADI, \_\_DD, \_\_EW/AC.

The effective date of the temporary service suspension is .

The reason for the temporary service suspension:

\_\_\_\_ Your conduct posed an imminent risk of physical harm to yourself or others and positive support strategies have been implemented to resolve the issues leading to the temporary service suspension but have not been effective and additional positive support strategies would not achieve and maintain safety, or less restrictive measures would not resolve the issues leading to the suspension.

\_\_\_\_ You have emergent medical issues that exceed this program’s ability to meet your needs.

\_\_\_\_ This program has not been paid for services.

Prior to giving this temporary service suspension notice, this program has at a minimum:

\_\_\_\_ Consulted with your support team or expanded support team to identify and resolve issues leading up to the issuance of this notice of temporary service suspension.

\_\_\_\_ Made a request to your case manager for intervention services or other professional consultation or intervention services to support you in this program.

This program has taken the following actions to minimize or eliminate the need for temporary service suspension:

The reason(s) why the actions and/or measures failed to prevent the temporary service suspension:

During the temporary suspension period, this program must provide information requested by you or your case manager. This program will work with your support team or expanded support team to develop reasonable alternatives to protect you and other and to support continuity of care.

If, based on a review by your support team or expanded support team, that team determines you no longer pose an imminent risk of physical harm to yourself or others, you have the right to return to receiving services.

If, at the time of the service suspension or at any time during the suspension, you are receiving treatment related to the conduct that resulted in the service suspension, your support team or expanded support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in your care or treatment when determining whether you no longer poses an imminent risk of physical harm to yourself or others and can return to the program.

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Name/Title/Signature Date

Name of provider, address, phone number

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| --- | --- | --- |
| Date mailed: | Name  | Title |
|  |  | Person |
|  |  | Legal Representative |
|  | Name of Case Manager:County of Financial Responsibility:Case Manager Phone Number:  | Case Manager |
|  | Fax to 651-431-7406 | DHS Commissioner (residential services only) |